TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Clear Lake Regional Medical Center

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-17-0173-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In closing, it is the position of the Hospital that all charges relating to the admission of this claimant are due and payable..."

Amount in Dispute: $2,089.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on September 30, 2016. Texas Administrative Code §133.307 (d) (1) states, "Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." As no response was received this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 5 – 8, 2016	Outpatient hospital services	$2,089.75	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in an

outpatient setting.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Charge exceeds Fee Schedule allowance (222)
   - 2 – CCI Comprehensive/component procedure (330)
   - 3 – The appropriate modifier was not utilized (402)
   - 4 – Items and/or services are packaged into APC rate. Therefore there is no separate APC payment (785)
   - 5 – This item is an integral part of an emergency room visit or surgical procedure and is therefore included in the reimbursement for the facility/APC rate (881)
   - 6 – 236 – This procedure or modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the NCCI edits or work comp state res/fee schedule requirements
   - 7 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 8 – P12 – Workers Compensation jurisdictional fee schedule adjustment
   - 12 – 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - 8 – Items, codes and services that are not covered by Medicare (779)
   - 16 – Additional recommendation is based upon additional supporting documentation received (CIQ377)

Issues

1. What is the applicable rule that pertains to reimbursement?
2. How is the maximum allowable reimbursement calculated?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement in the amount of $2,089.75 for outpatient hospital services rendered on February 5 - 8, 2016.

   The insurance carrier reduced the disputed services with reduction codes, P12 – "Workers compensation state fee schedule adj," 236 – "This procedure or modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the NCCI edits or work comp state res/fee schedule requirements," and 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   The Division finds that the outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

   The Division will discuss the applicable rules and fee guidelines below to determine if these denials and/or reductions in fees were appropriate.

2. The applicable Medicare payment policy are located at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

   The resources that define the components used to calculate the Medicare payment for OPPS are found below:

   - **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,

- *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.

- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.
- **Multiple procedure discounts -** Multiple surgical procedures furnished during the same operative session are discounted. The full amount is paid for the surgical procedure with the highest weight; Fifty percent is paid for any other surgical procedure(s) performed at the same time;
- **Composite** - Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

28 Texas Administrative Code §134.403 (f) states in pertinent part,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent;

The reimbursement calculations is as follows:

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.9615	40% non-labor related	Payment	Maximum allowable reimbursement
71020	5521	Q3	$60.80	$60.80 X 60% = $36.48	$36.48 X 0.9615 = $35.08	$60.80 X 40% = $24.32	$35.08 + $24.32 = $59.40	$59.40 X 200% = $118.80
29880	5122	T	$2,395.59	$2,395.59 X 60% = $1,437.35	$1,437.35 X 0.9615 = $1,382.01	$2,395.59 X 40% = $958.24	$1,382.01 + $958.24 = $2,340.25	$2,340.25 X 200% = $4,680.50
							Total	$4,799.30

The remaining services are classified as follows:

- 28 Texas §134.403 (d) states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided." Per Medicare National Correct Coding Initiatives (CCI) found at www.cms.gov, procedure code 96360 may not be reported with procedure code 29875 billed on the same claim. Payment for this service is included in the payment for the primary procedure. The carrier denied as 236 – "This procedure or modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the NCCI edits or work comp state res/fee schedule requirements." Based on CCI edits, the carriers denial is supported.
- Procedure code J2250 has status indicator N denoting packaged codes with no separate payment. The carrier denied as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Based on the status indicator, the carrier's denial is supported.
- Procedure code J2704 has status indicator E denoting excluded or non-covered codes not payable if submitted on an outpatient bill. The carrier denied as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Based on the status indicator, the carrier's denial is supported.
- Procedure code 80048, date of service February 5, 2016, has status indicator Q4 denoting packaged APC payment if billed on the same claim as a HCPCS code assigned published status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." The carrier denied as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Based on the status indicator, the carrier's denial is supported.
- Procedure code 84703, date of service February 5, 2016, has status indicator Q4 denoting packaged APC payment if billed on the same claim as a HCPCS code assigned published status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." The carrier denied as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Based on the status indicator, the carrier's denial is supported.
- Procedure code 85027, date of service February 5, 2016, has status indicator Q4 denoting packaged APC payment if billed on the same claim as a HCPCS code assigned published status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." The carrier denied as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Based on the status indicator, the carrier's denial is supported.
- Procedure code J1040 has status indicator N denoting packaged codes with no separate payment. The carrier denied as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Based on the status indicator, the carrier's denial is supported.
- Procedure code J2405 has status indicator N denoting packaged codes with no separate payment. The carrier denied as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Based on the status indicator, the carrier's denial is supported.
- Procedure code J3010 has status indicator N denoting packaged codes with no separate payment. The carrier denied as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Based on the status indicator, the carrier's denial is supported.
- Procedure code J7030 has status indicator N denoting packaged codes with no separate payment. The carrier denied as 97 – "The benefit for this service is included in the payment/allowance for

another service/procedure that has already been adjudicated." Based on the status indicator, the carrier's denial is supported.

- Procedure code J7120 has status indicator N denoting packaged codes with no separate payment. The carrier denied as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Based on the status indicator, the carrier's denial is supported.
- Procedure code 93005, date of service February 5, 2016, has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date. The carrier denied as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Based on the status indicator, the carrier's denial is supported.

3. The total allowable reimbursement for the services in dispute is $4,799.30. This amount less the amount previously paid by the insurance carrier of $5,049.81 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		November 10, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.